

The Linacre Quarterly

*A Journal of the Philosophy
and Ethics of Medical Practice*



**FEDERATION OF
CATHOLIC PHYSICIANS' GUILDS**

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The Linacre Quarterly

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The International College of Surgeons will hold its Congress at Madrid, Spain, May 20,-23, 1952. This time coincides with the 35th International Eucharistic Congress to be held in Barcelona.

International Catholic Travel Service, a division of LANSEAIR, is planning a series of pilgrimages for the Catholic surgeons which will include both events. Anyone planning to attend the Congress at Madrid might wish to contact the above Travel Service at 109 W. Dearborn, Chicago 2, Illinois for further information.

Editorial

BEWARE OF GREEKS Bearing Gifts!" The letters were large. The color of the chalk was gold. The phrase was triply underlined. No matter where you sat in the lecture hall, the motto was visible and impressive. The dullness of the course in pharmacology encouraged repetitious imprints on your brain. The instructor was not helpful. To the question, "Why does such a warning occupy the whole upper third of the lecture board?" the answer was, "Time will tell." The course ended and the explanation was not forthcoming. Years passed, but the picture image is permanent.

In daily practice, the "Gifts" appear: white pills, pink pills, green pills, blue pills, yellow pills; white capsules, pink capsules, green capsules, blue capsules, yellow capsules; liquids as varied; ointments as numerous; syrups; powders. When the desk is groaning under the heap, the authenticating articles appear: first, the famous-named cautious report; then the less famous-named enthusing observation; finally, the unknown rabid flag-waver. You say you're not convinced? You say you want more—an attractive letter-opener, a permanent desk blotter, a perpetual calendar, an expensive volume with beautiful color plates, a year's supply of hand lotion for home and for office. O, yes! and a monthly bulletin of diseases folded nicely into glamorous lack of censorship that would make lay publications screech with envy.

And the "Greeks Bearing!" Adonis was an amateur. The suit of wool from the West of London, the homburg of Danbury Hatters, the hand-painted ascot, the high shine, are coupled with a knowledge of medicine to shame Osler, a diction to top the Barrymores, an etiquette acceptable to the Court of George. The bag is top grain. The containers suggest longer hours of design than the research of the product contained. Perhaps, in fact, the efficacy of the content is increased by contemplation of the total vision.

You mentioned the Cost? Doctor, you must realize the background of the manufacturer, the modern scientific laboratories,

the costly equipment, the subsidized research men, the annual trips to the home laboratories of the "Greeks." Again, you have the research grants carefully blanketing the country, the booth rentals to support the many medical conventions, the philanthropic donations to selected charitable institutions, of many cans, hundreds of packages, thousands of capsules, millions of pills. The medical magazines, too, must be kept solvent by the advertising—the more grateful the manufacturer, the larger the amount of gold-plated space. Exit, the bearers.

Misgivings? — Yes, there are some. Arguments against? — definitely. Scientific inaccuracies? — surely. Time mellows. Patients repeat. The white is psychologically dull; the pink, a repetition; the green, bilious; the blue, constipating; the yellow, allergic. "Well, Mrs. McGillicuddy, this is the very latest, the most accurate, and although it hasn't been used much locally, clinical reports are excellent; of course, some patients would call it pure gold because of its price. Yes, agreed; to get well is worth money—take according to directions, then." Forthwith and to furtherance, the grotesque cost of illness is sanctioned and victorious are the "Greeks Bearing Gifts."

WILLIAM J. EGAN, M.D.

The Guild of St. Luke of Boston

The Real Issue—Political Versus Private Control of Medicine

By the Most Rev. Karl J. Alter
Archbishop of Cincinnati

THE AUTHOR of the following article is one of the country's most distinguished authorities in the field of social service. He is a former Director of the National Catholic School of Social Service, Washington, D. C.; was an original advocate of fact-finding boards for the settlement of labor disputes; has served as a committeeman or officer with the National Conference of Catholic Charities, the Ohio State Department of Welfare, the Social Service Federation, the Toledo Chapter of the American Red Cross, the Toledo Council of Social Agencies, the Toledo Community Chest, among other organizations. He is a former Episcopal Chairman of the Department of Social Action, National Catholic Welfare Conference and past chairman of the Administrative Board of the Catholic Hospital Association. He inspired and guided the joint statement of the Conference of Catholic Charities, the Bureau of Health and Hospitals of N. C. W. C. and the Catholic Hospital Association on compulsory health insurance. The article was written for the N. C. W. C. News Service.

Socialized Medicine

The recent press notices which implied in their headlines that the Holy See had put its stamp of approval on "socialized medicine" do not seem to be justified by a correct reading of the text itself. Monsignor Montini, the Undersecretary of State for the Vatican, on the occasion of the recent annual meeting of the *Semaine Sociale* in France wrote a letter to Charles Flory, the president of the organization, in which he discussed the need and urgency of making health services available to the public. He spoke of the concern for placing within everybody's reach medical care of high standards; but nowhere did he mention that the State would supply this service directly under a nationalized, exclusive, and compulsory tax program. In fact he warned against certain abuses of a moral nature which might creep into a State medical

program. The newspaper headlines were misleading and the conclusion that the Church favored socialized medicine, as understood here, was quite unwarranted.

It will help to clarify the import of Monsignor Montini's discussion of this subject if the two following paragraphs taken from his letter are studied. They emphasize a definite but limited responsibility of the State to make provision for the public health. They also emphasize that the State's responsibility is to support and coordinate as needed the efforts of private enterprise. They recognize in addition that with the assistance of the State there will be more efficacious and more rapid action.

"Certainly there could be no question of contesting the rights and the duties of the state in the matter of public health and especially in favor of those who are less fortunate, of those whom poverty renders less provident and more exposed. A just legislation on hygiene, preventive medicine, and adequate and sanitary housing, the attempt to provide everyone with the best medical care, the elimination of social plagues such as tuberculosis or cancer, a legitimate preoccupation for the health of young generations and many other measures that encourage the health of the body and spirit in the framework of wholesome social relations—all this cooperates toward the prosperity of a nation and its interior peace.

"However, in the framework of modern civilization only the state, supporting, coordinating, when needed, with private enterprises, has its own means for 'a more universal, more concerted and consequently more efficacious and more rapid' action. (Address, June 27, 1949). But these achievements in the field of security, of medicine, or of assistance ought to conform themselves to the moral principle of respect for men and for the family. Unfortunately, fear in this matter is not unwarranted."

The point at issue is not whether moral abuses can and do exist in the private practice of medicine or in the voluntary group-organization of health services, but whether these dangers are not greater (especially in view of our overwhelmingly secularist society) if the State imposes a compulsory tax for a uniform health program on all the citizens. There is always the remedy in

private or voluntary programs of refusing financial and moral support as well as of voicing effective criticism. When the State undertakes to tax every citizen to support its own uniform program of public health, what redress do the citizens have against possible social policies such as sterilization, birth control, euthanasia? They may protest; but they will be taxed in spite of their protests. In some states we already have some features of these objectionable programs enacted into law. It is quite possible that these policies might be incorporated into a nationalized program and the damage would be so much the greater.

The Fundamental Issue

It can be readily admitted that this is not the immediate intent of the advocates of socialized medicine and that it is not the most disturbing feature of a nationalized health program. The fundamental issue is whether such a program could actually produce the net results which are so euphemistically described by its advocates. The debate furthermore should not be joined on the question of whether there are health needs not now satisfied, nor on the catastrophic impact of prolonged and serious sickness on the family budget; nor even on the advantage and necessity of prepayment of medical and hospital costs. All these aspects of the problem are accepted without debate by social students. The real issue is whether we can achieve a better result with a limited state program in conjunction with voluntary insurance and private initiative, or whether we must have a universal, compulsory tax-supported program under direct governmental control. The experience with the health services now being rendered by government on the local, state, and national levels does not offer much encouragement to a further extension of government services in this field. It is altogether exceptional to find the quality of medical and health service as high in the government-controlled institution as in the equivalent institutions conducted under private or voluntary auspices. A survey of county hospitals and the services made available for the medically indigent by city governments will convince any skeptic in the premises. It has not been found possible to eliminate certain elements of partisan politics from the policies and management of these institutions and services. There is frequent bickering over budgets, appointments, and division of

responsibility, with consequent deterioration of service, as anyone can testify who has had practical experience in the field of social work.

If we look abroad we find greatly divided judgments on the success of nationalized health programs. The length of time during which Great Britain's program has been in effect does not permit as yet a decisive judgment. The medical men of England are not satisfied with the present setup, and are currently threatening to strike unless their fees are increased. This means of course increased taxes, in spite of the fact that the budget is already far in excess of anything originally contemplated. Hospital facilities are declared to be utterly unequal to the demands, with the result that there are long delays in the admission of even urgent cases. More hospitals mean more expense, and of course more taxes. The argument is not that there should be no further development of facilities with more taxes, but that the rosy forecast of costs has proven to be extremely fallacious. Other forecasts may in the end be equally fallacious as to the future health standards of the entire nation under a nationalized system of health.

Facilities and Personnel

The first question which must be discussed in any sound public health program is whether the necessary facilities and personnel actually exist to warrant the promises made by the advocates of nationalized medicine in providing universal health services. If adequate facilities and adequate personnel do not now exist, then no program under any auspices can be a success. The fact is that, on the government's own admission, these essential requirements are not now available and cannot be made available for quite some years. It will take many years to train the necessary number of medical doctors and an equal number of years to train sufficient hospital administrators, nurses and technicians, not to speak of the huge sum of money required to finance a building program of adequate dimensions. It seems utterly unfair, even if otherwise desirable, to start a universal tax collection before there can be a universal service program to meet the needs. This is only one objection among many others.

The advocates of a compromise program do not deny governmental responsibility for the health of the public; but they do

object to the folly of getting the cart before the horse. Such is the case when the government promises health services for everybody, in spite of the acknowledged fact that they are not yet universally available. If the government would provide more grants in aid for the building of hospitals and medical schools, and establish a form of subsidy for doctors and nurses in the sparsely settled areas with access to health clinics to be developed in these rural areas, then it would be rendering a most constructive service to the nation. Such a program is the real test of the sincerity of purpose on the part of government. If however the objective of the government program is to get control rather than help to extend health services, then of course a compulsory health tax and nationalized administration are necessary.

Need Aid, Not Control

It will require all the resources which the federal budget can muster for many years to come, in order to meet the minimum requirements of a universal health program. There is a great shortage of doctors, nurses, hospitals, clinics and other facilities, in spite of the fact that there is a higher ratio of these services in the U. S. A. than in any other country of the world. We need government aid to provide the additional services. We do not need control. The provision of hospital and medical care can well be left to voluntary efforts such as Blue Cross, Blue Shield, Farm Bureaus, and other forms of voluntary insurance programs. Anyone who sincerely wants health and hospital insurance can get it now at reasonable cost and at a figure which no government system could match. We say this because now we have available tens of millions of dollars of donated service which no government could ever command. The medically indigent are now and always will remain a direct charge on government.

There is a place for government in the health program of the nation; but it is not that of a dictator in an omniscient state. The principle of 'subsidiarity of function' is absolutely valid in the premises. The supposition that hospitals and the medical profession would or could remain free and autonomous under any of the proposed nationalization schemes is a chimera and a mirage. The government contract would always be the controlling instrument; and the government contract would not be subject to collective

bargaining, as anyone knows who has dealt with government agencies. One simply signs on the dotted line — or else.

There has been plenty of debate and argument on this question of 'socialized medicine.' The discussion most frequently starts from false premises. The thing is a misnomer. There must always be a social aspect to health and a social responsibility. The real issue is political control and nationalization versus private and voluntary control. Government cannot be permitted to evade its share of responsibility; but government should not be permitted to assume the dominant responsibility. Let government help financially to support a program of universal health service, but let voluntary institutions and agencies provide the service. The area of chronic illness, the field of contagious disease, and the situation which requires the exercise of police powers belong to government. No one competent to judge will gainsay this proposition. The government cannot fulfill its own particular responsibility without taxes, but let them be included in the regular budget without the pretense of a phony insurance system.

Conflicting Protestant Views on Euthanasia

Francis P. Furlong, S.J.

“EUTHANASIA-PRO” and “Euthanasia-Con” are companion chapters in *The Ethical Basis of Medical Practice* by Dean William A. Sperry of the Harvard Divinity School. The same tragic uncertainty in this matter of life or death is shown by companion articles in the Protestant journal, *Theology Today* (July, 1951, pp. 194-212). There John Sutherland Bonnell defends “The Sanctity of Human Life” and Joseph Fletcher attempts to prove “Our Right to Die.”

It might interest Catholic medical men to consider these extreme divergent Protestant views. No new arguments “Pro” or “Con” are introduced. Hence, for the most part I shall but report the line of thought without formal approval or rebuttal. For material on the Catholic position, and for the formulation of the convincing arguments against euthanasia together with the answers to the objections advanced, I refer the interested reader to Father Gerald Kelly’s survey of recent literature on euthanasia in “Medico-Moral Notes” (LINACRE QUARTERLY, November, 1950, pp. 3-9).

I. “THE SANCTITY OF HUMAN LIFE”

Euthanasia for Whom?

Dr. Bonnell mentions that the medical men who are advocating a bill favoring euthanasia in New York would want to include not only those suffering from an incurable and painful disease, but also mental defectives and others incapable of giving consent. Seriously malformed and idiotic children, for instance, should be given an easy death, they would reason, since there is so little accommodation in public institutions for these wretched creatures, so distressing, and so useless. As a matter of expediency, however, for the *present* the Euthanasia Society of America campaigns only for *voluntary* euthanasia, as the measure which will encounter the

least opposition. "Every thoughtful person must realize that once the principle of euthanasia is conceded, its application will almost certainly be broadened to include all these classes."

Considerations Urged Against Euthanasia

1. "The suggestion that in some circumstances death is more desirable than life may well promote a wave of suicides among neurotics and others of weak and unbalanced mind."

2. "Doctors who oppose the project fear that the legalization of euthanasia would result in many so-called 'justifiable homicides,' . . . legal justification for the taking of a human life under certain circumstances would provide potential infanticides [e.g. in the case of illegitimacy] with a kind of moral sanction."

3. "Again, a question is raised as to whether such far-reaching powers ought to be invested in the state." (I cannot refrain from remarking here that in asking: "Are we prepared to give the state authority in so vital an area?", Dr. Bonnell seems to suppose that we have the power to give such rights. Most certainly we have no such power. God alone has the dominion over human life. And it is not the state but God Himself who "concedes the right to take a human life in battle, in certain cases of self-defense, and in capital punishment.")

4. The line cannot be held at *voluntary* euthanasia. One of the gravest offenses charged against the Nazis was a program aimed at the elimination of "useless eaters," the crippled, the incurably ill, and the hopelessly retarded or insane among the German people. Our fellow Americans, we trust, are not motivated by Nazi utilitarianism but by human compassion. Now:

"If the benefits of a painless death are in certain cases as great as its advocates contend, one wonders on what principle of compassion this blessing is withheld from a great proportion of sufferers merely because they cannot request a merciful release. Furthermore, why should this boon be given only to the sufferers from physical pain? Many people contend that mental suffering is more intolerable than even the most acute physical agony. The moment these issues are raised one sees that the principle of euthanasia reaches into almost every area of human life."

5. Once we have extended the law to include the hopelessly crippled, "How should we know whether or not such a cripple might not ultimately become a greater asset to the community than many people who are rated physically normal?" Examples of this, such as Steinmetz, are not wanting.

6. "If the principle of euthanasia should ever be generally adopted it will rob the medical profession of one of its most valuable assets—the confidence inspired in the patient by the fact that the physician has ever been regarded as a sustainer of life. Back of the modern doctor is an age-old tradition of prolonging life while making the patient as comfortable as medical skill permits. Now, if in addition to the function of healer is added, on occasion, that of life-taker, a powerful factor in the building of the patient's morale will be lost."

7. What kind of human society would result if euthanasia were generally practiced? "Even though the patient may be unaware of the loving solicitude of those who care for his every need, it ministers to the moral and spiritual enrichment of those who so unselfishly cherish even the hollow shell of one who is dear to them."

8. Pain undoubtedly has a constructive part to play in individual character formation. "We have all been inspired by the sight of someone courageously meeting the challenge of incurable illness and pain, quietly fulfilling the tasks of life while strength permitted, and at last going out with all the trumpets sounding."

9. Dr. Bonnell considers that: "The principal argument advanced by the medical men is that the benefits of narcotics in the case of patients who are incurably and painfully ill are progressively decreased." Hence he answers this argument more at length.

"Constant advances are being made in the production of more effective narcotics and in the techniques of nerve blocking. But a far more significant and hopeful development has appeared. It may well revolutionize medical thinking on the subject of the relief of intractable pain. I refer to the surgical operation known as 'unilateral prefrontal lobotomy'."

In confirmation of this the very impressive report of a leading United States neuro-surgeon is quoted. This particular doctor has

performed unilateral prefrontal lobotomy on approximately one hundred and fifty patients. In seventy per cent good results were obtained. For him good results meant that the patient no longer spontaneously complained of pain or asked for analgesic medication. Fair results were obtained in fifteen per cent in that these patients continued to complain of some pain, but required far less medication than before. Failure resulted in the remaining fifteen per cent where the pain continued unchanged. Though even some of these were relieved of their pain by performance of a lobotomy on the second side of the brain.

All of the above patients were suffering from pathological conditions. The majority of them had malignant tumors, many of which were so located that no other type of surgery could relieve the pain. As to personality changes the surgeon wrote: "The prefrontal lobotomy . . . produces no detectable alteration either in the intellect or personality of the patient. . . . Even the patient badly debilitated by widespread malignant disease tolerates the unilateral lobotomy with amazing ease." The author testifies that he "has witnessed the almost miraculous results accomplished by the operation in the relief of intolerable pain."

10. The final argument is, of course, ethical and spiritual. We are the inheritors not only of the spiritual tradition of the Jewish faith, but above all of Christianity. Followers of the Great Physician would do well to remember that: "Christianity has never ceased to emphasize the sanctity of human life and the value of the individual, even the humblest and lowliest, including the afflicted in mind and body."

II. "OUR RIGHT TO DIE"

What are your objections against euthanasia? Professor Fletcher feels that he has an answer for all of them. An answer when you argue from, "Thou shalt not kill" to conclude that euthanasia is an invasion of God's right to determine when life shall end, and hence suicide or murder. An answer to the claims that suffering is a part of the divine plan; or that "incurables" have been cured; or that euthanasia might be requested impulsively or extended disastrously, or abused dastardly. An answer, finally to such fears as: "The ethics of physicians forbid them to take

life;" or: "Doctors do not want euthanasia made legal;" or: "Euthanasia would stop medical research."

I need not repeat here Professor Fletcher's familiar arguments in favor of euthanasia. They are refuted, every one of them, in the current literature on the subject. My point now is that the earnest presentation of this view in a Protestant theological journal as one side of a freely debated question, bears witness to the fundamental confusion and uncertainty in the minds of many today.

Professor Fletcher Objects

Some notes which I made as I went through Professor Fletcher's article may be of interest as indicative of this particular non-Catholic mentality.

1. Euthanasia is suicide. — The author concedes this, but asks whether we do not have some right to commit suicide. To show that we have such a right he appeals to the case of the hero, the martyr, and all those who deliberately give their lives. (Professor Fletcher, may I remark, is aware of the distinction between willing something *directly* or *indirectly*, but he does not appreciate what the distinction implies. What a tremendous moral difference there is between simply permitting an unavoidable evil effect as the by-product of a good action, and wanting that evil effect either in itself or as a means to something else.) To him, then, to make the point that the suicide *directly* seeks to end his life, "is only to raise the question of what purposes are sufficient to justify the loss of one's life."

2. Euthanasia is murder. — Legally, Professor Fletcher maintains, "malice aforethought" may signify nothing more than premeditation, but morally we must weigh the motive. The means (taking life) is the same in murder and euthanasia, but the motive is entirely different. Is there not a difference between a parent who saves to benefit his children and one who saves out of avarice? Just as the motive makes the difference there, so are murder and euthanasia quite different. (As a Jesuit moralist, I must recall here that the calumny spread was that we Jesuits taught: "The end justifies the means." Then, too, here we see no attempt made to distinguish a means that is evil from a morally indifferent means.)

3. God has reserved for Himself the right to determine when life shall end. — He replies that if this argument is valid, then we should not try to *lengthen* life either. So the Roman Catholic divine-monopoly theory about life is wrong. (One good effect which follows from the proposal of false views of life is the refutation of specious argument. For instance, it was of this same objection of Professor Fletcher that Dr. John F. Conlin, Director of Medical Information and Education, Massachusetts Medical Society wrote:

“Those who argue for euthanasia would impale their antagonists by urging that if it be not permissible to shorten life, it follows with equal force that it is immoral to lengthen or prolong life. This is a full-blown *non-sequitur*. The Redeemer of the human race raised the dead to life, gave sight to the blind, healed lepers and Himself submitted to the agony of the Cross. There is adequate argument favoring the physician’s healing work, none for the evil advocated by the proponents of euthanasia.”

Dr. Conlin’s whole article is very good. It was published as “Euthanasia: ‘Unethical, Immoral’ ” in *Pastoral Psychology* for September 1950, pages 35-38. Since it is pretty much of a rebuttal of an earlier article by Professor Fletcher defending euthanasia, it may be of special interest to some doctors challenged by my mere reporting these arguments here.)

4. The ethics of physicians forbid them to take life. — “We recognize that as a fact,” Professor Fletcher says, “but the issue is raised precisely because there are cases where the doctor’s duty to prolong and protect life is in conflict with his equal duty to relieve suffering.” (It is to be noted that the doctor’s obligation to relieve suffering can extend only to moral means which are in accord with the law of Almighty God. A doctor certainly cannot be obliged to do evil and take an innocent life, in order to accomplish any good whatsoever, relief of suffering or anything else. The doctor in fact, like anybody else, is obliged *not* to do evil.)

5. Doctors do not want euthanasia made legal. — He quotes the *AMA Journal*: “Doctors know that cases arise when decisions have to be made on this supreme matter. What they will strongly oppose is any effort to legalize such a course of action.” His idea seemingly is to bring it out in the open. He makes this striking assertion: “At a recent meeting of a medical society in the Middle

West, a speaker asked for a show of hands from those who had never administered euthanasia. Not a hand was raised." No reference is given as to where and when the meeting took place, nor is any information given as to who attended it. (Human legislatures, of course, can never veto the enactments of the Divine Lawgiver. Evil no matter how commonly practiced does not thereby become good.)

Euthanasia for Whom?

As to the extent to which euthanasia is to be applied, Professor Fletcher's thought is:

"In conclusion, it should be pointed out that there are three schools of thought favoring euthanasia. First, there are those who favor voluntary euthanasia, a personalistic ethical position. Second, there are those who favor involuntary euthanasia for monstrosities at birth and mental defectives, a partly personalistic and partly eugenic position. Third, there are those who favor involuntary euthanasia for all who are a burden upon the community, a purely eugenic position. Logically we do not have to endorse the third school of thought just because we are in sympathy with either the first or the second, or with both of them."

Even in that conclusion, Professor Fletcher makes it abundantly clear that once the line of defense against legalized murder is broken, it never will be held at *voluntary* euthanasia. Significantly with reference to the proposed New York bill he remarks: "It leaves aside the whole question of eugenic euthanasia for solution at another time and by other legal instruments."

III. CONCLUSION

The articles discussed above afford us, I believe, another object lesson in the importance of competent guidance in a confused world. Despite obvious good will, obscurity and uncertainty remain in the thinking of those who do not have some authoritative and trustworthy norm to follow. Our code of *Ethical and Religious Directives for Catholic Hospitals* not only tells us that: "*Euthanasia* in all its forms is forbidden," but also directs us to satisfying sources explaining how this conclusion is arrived at.

The above articles, too, to my mind, add weight to the remark: "Catholic physicians do not sufficiently appreciate the wonderful guidance which they receive from the Church on the ethical matters of our profession. It is pointed out to us in clear reason and in high morals, and not in mawkish sentimentality, what our proper attitude must be in the many controversies raised by our less favored confreres" (LINACRE QUARTERLY, April 1939, p. 27).

Editorial comment, finally, on page 152 of that July number of *Theology Today* tells us that: "The two [articles] dealing with euthanasia were written in view of the introduction into the several state legislatures of bills which would legalize, under certain restricted circumstances, the taking of life of those suffering from an incurable disease." So responsible Catholic doctors may be obliged to oppose the enactment of immoral laws in this regard. To this end, it helps to know what some others think or feel. We stand sure with those who champion "The Sanctity of Human Life," and reject as false "Our Right to Die" construed to mean a right to intend our death either for its own sake or as a means of getting something else we want.

*Unnecessary Surgery

Gerald Kelly, S.J.

1. Will you kindly tell us whether it is morally wrong — and if so, why it is wrong — for a doctor to remove a healthy appendix, healthy tonsils, or a healthy gall bladder merely because a person asks for one of these operations. 2. Also, is it permissible to do a cesarean section merely because the mother does not want to go through the inconvenience of normal labor?

I WISH I could say that these questions are only the result of speculative classroom discussion, but that is not the case. They are practical problems that have been presented in some places even by members of the medical profession, who seem to think that a person may do what he wants with his body: hence, if he wants an operation, that is his business. It is good to note that this attitude is certainly not common, for it indicates not only hazy moral principles, but also inferior professional standards. The generality of doctors realize that surgical operations are justifiable only within certain limits; and they are professionally conscious of the fact that the judgment concerning the need or advisability of such operations rests with them, not with their patients. They are professional men with personal responsibility, not the hired employees of their patients.

Nevertheless, though the doctor is not the employee of the patient, he does *act for* the patient when he performs an operation. By this I mean that it is the patient who has the right, under certain circumstances, to mutilate himself; and when he submits to a surgical operation he exercises this personal right through the doctor. The doctor may operate only with the consent, at least reasonably presumed, of the patient or his qualified guardian; and he may perform only such operations as fall within the rights of his patient. If the patient is not morally justified in having an operation, the doctor is not morally justified in performing it.

It behooves us, therefore, to determine clearly just what right an individual has over his own body. Speaking of this right, theologians describe it as one of reasonable administration, but not

of absolute ownership. Translated into terms of surgical operations, this principle of "reasonable administration" means that such operations are permissible for *proportionate* reasons that concern the preservation or restoration of physical well-being. On the basis of this principle of reasonable administration we can permit such things as the removal of diseased organs, or even of technically healthy organs when this is necessary for the suppression or prevention of a threat to life or health. Under reasonable administration, too, we might class plastic or other surgery which is directed to the removal of abnormalities. But in all these cases there must be a *due proportion* between the good to be accomplished by the operation and the damage or risk involved in it.

First Question

Over the years during which I have conducted this column I have touched on various aspects of justifiable and unjustifiable mutilation. Of special pertinence to the operations mentioned in the first of the present questions, is an article entitled "Incidental Appendectomy," which appeared in *Hospital Progress*, November, 1948, pp. 393 ff., and which is now reprinted in *Medico-Moral Problems I*, 35-39. The article contains a much more complete analysis of the principle of reasonable administration than I have given here, and applications of this principle to operations for the removal of an apparently healthy appendix or healthy tonsils. Regarding these operations, let me briefly review here the conclusions reached in that article.

1. An apparently healthy appendix may be removed when the abdomen is open for some other operation and when the appendectomy can be performed without adding undue risk for the patient. In this case the principle of due proportion is observed, because the patient has much to gain and little to lose by the appendectomy. The revised hospital code explicitly permits this operation at the discretion of the physician." (Cf. *Ethical and Religious Directives for Catholic Hospitals*, p. 7.)

2. On the other hand, a complete appendectomy (including the opening of the abdomen for the specific purpose of removing the appendix) is not usually justified in the absence of medical indications for the operation. In this case the patient exposes himself to

the risk inherent in abdominal surgery, as well as to possible serious consequences (e.g. adhesions, obstructions in later life), when he has a good chance of avoiding these dangers entirely. It may be true that in present-day surgery the risk is minimal, but there is always some and there is always the latent danger of post-operative complications. Moreover, in the usual circumstances of modern civilization, a person who needs an appendectomy can get it with comparative ease and with sound assurance of a successful outcome. Hence, to submit to the operation in the absence of medical indications is to violate the principle of due proportion: the patient has much more to lose than he has to gain.

3. As for the removal of healthy tonsils, I pointed out in my former article that this too violates the principles of due proportion. Any danger that might be involved in the possession of the tonsils can be sufficiently counteracted by the removal of the tonsils when symptoms of disease make their appearance.

4. In my former article on appendectomy I referred to an *unusual* case discussed by Father Francis J. Connell, C.S.S.R. This case concerned a missionary who was going to a place where expert surgical aid would not be available and where, as a consequence, an attack of acute appendicitis might mean a fatality. Father Connell is of the opinion that the special circumstances of this case would justify a purely preventive appendectomy before the missionary leaves civilization. I agree with his analysis. Both of us, however, would admit that there might be legitimate debate over the question, and we would not propose our opinion as more than probable. Incidentally, I might mention here that several eminent physicians, with whom I discussed all the material pertaining to this article and who say that my conclusions represent sound medicine as well as sound morality (as is generally the case), also suggested that some allowance might reasonably be made for the emergent nature of appendicitis when a person is going into circumstances in which proper surgical care would be lacking.

The reasons for permitting an appendectomy in the conditions described above (nn. 1 and 4), are the relatively slight value of the organ itself and the genuine statistical probability that an appendectomy may be needed in later life. Neither of these reasons is valid with reference to the removal of a healthy gall bladder. It is an organ with a definite function and, though obviously not

indispensable, it is important in the total economy of bodily integrity. Moreover, the probable need of an operation, and especially of an emergency operation, in later life is comparatively slight. The reasonable care of the body, therefore, demands that cholecystectomy be allowed only when medical indications call for it.

Cesarean Section

Cesarean section involves not merely the principle of reasonable administration of the mother's own body, but also her natural duty to make reasonable provision for the safety of her child. As far as I can gather, both from reading obstetrical literature and from consulting competent obstetricians, cesarean section does not yet approach the safety, for either mother or child, of normal vaginal delivery.

Besides the risk inherent in the operation itself, cesarean section brings on other unfavorable consequences. It leaves a scar on the uterus which decreases the normal physiological power of the uterus to safely carry future pregnancies to term. According to many obstetricians, it means that all future deliveries must be by cesarean section; and according to all, it increases the probability that future cesareans will be necessary. It often produces troublesome adhesions in the peritoneal cavity, and it creates a danger of rupture of the uterus in subsequent pregnancy. And because of these various consequences, it frequently induces vexing moral problems concerning sterilization.

The foregoing considerations make it obvious that the mother's desire to avoid the inconvenience of vaginal delivery is not a proportionate reason for cesarean section. According to sound obstetrics, cesarean section is permitted only in the presence of definite indications that in a given case it would be safer for the mother and/or the child than would vaginal delivery. Sound morality concurs in this rule.

Conclusions

On the basis of the explanations given in this article and the article on incidental appendectomy, I would give these brief answers to the questions proposed:

1. It is not permissible to remove a healthy appendix, healthy tonsils, or a healthy gall bladder merely because a person asks for one of these operations. The principle of reasonable administration of the body allows for the excision of healthy organs only when special circumstances constitute a proportionate reason for the operation.

As for appendectomy, the required special circumstances are present when the abdomen is open for another reason and the appendix can be removed without undue increase of risk. There is also sound probability for allowing an appendectomy in conditions equivalent or similar to the case of the missionary who will spend his life in a place where appendicitis would prove a fatality.

Except for such special reasons as I have just indicated, appendectomy, tonsillectomy, and cholecystectomy are morally justified only for medical indications.

2. Cesarean section is major surgery which usually entails greater risk than vaginal delivery for both mother and child, and which is accompanied and followed by other unfavorable factors. It is permissible, therefore, only for sound medical reasons. The mere desire of the mother to avoid the inconvenience of normal delivery does not constitute such a reason.

* * * *

As a postscript to what I have written, I should like to add that unnecessary surgery can undermine some of the insurance programs that are now great benefits to the sick. This is an extrinsic, but by no means negligible, reason for taking a firm stand against unnecessary operations.

* This article was published in *Hospital Progress*, June, 1951. It is reprinted here at the suggestion of some doctors who thought that physicians would like to see it and that they would be more apt to see it if it were published in LINACRE QUARTERLY.

The President's Page

THIS "PRESIDENT'S PAGE" is an innovation for LINACRE QUARTERLY. The Editor has generously offered this space as an outlet for expression by your President.

The best way I can think of to launch this page is to give a simple, straightforward statement of my personal concept of the Federation, of its makeup, its objectives and its limitations.

First, what is the Federation, as I see it? And what is it not?

The Federation's full name accurately describes and delimits it. As I understand it, it is a confederation—a loose-knit aggregation of autonomous, co-equal Guilds, each with full "states' rights." The Federation is not a national society, or a totalitarian organism, of which the Guilds are subordinate branches, or "locals."

These individual co-equal Guilds are the diocesan vehicles by which Catholics who are also physicians (or surgeons) can take their part in Catholic Action. Each Guild's members initiate and carry through their own specific programs. Such programs must necessarily be in accord with the mind of the Church. They must have the approval of the Bishops of the separate dioceses. Lacking that accord and that approbation, no Guild has the right or privilege to present itself as representative of the Church.

Each Guild has its Priest Moderator, representing the Bishop. The Moderator does not propose or formulate policies. As the Bishop's liaison man, he only guides and keeps his Guild in line with the mind of the Bishop—that is, of the Church.

"Why, then, do we have and need the Federation?" some may ask. The best answer I can give is the example of our American Archbishops and Bishops in having set up our National Catholic Welfare Conference. NCWC is this Bishops' clearing house for discussing questions and problems that arise in their autonomous jurisdictions.

By analogy, then, our Federation is the "NCWC," the clearing house, for questions and problems and proposals that arise in our individual Guilds. The Federation does not dictate overall policies and impose them on the member Guilds. All policies that come before the Federation come up—or rather

come in—from the Guild “grass-roots.” Only insofar as these policies offer some solutions of common or universal application are they likely to become “Federation policies.”

Necessarily, such policies must conform to basic rules that I cited at the outset: They must conform to the mind of the Church and must have approval of the Bishop to be operative in any diocese.

THIS SUMS UP your President’s personal, subjective ideas of what your Federation is, what it is not; of what it should do and what it should not essay to undertake.

If you agree, may I hear your “ayes?”

If you don’t, may I hear your “nays” and “why nots?”

WILLIAM P. CHESTER, M.D.

President, The Federation of Catholic
Physicians’ Guilds

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